

Larchwood Care Homes (South) Limited

Brookes House

Inspection report

79-81 Western Road
Brentwood
Essex
CM14 4ST

Tel: 01277212709

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Ratings

Overall rating for this service

Good 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Good 

Summary of findings

Overall summary

Brookes House provides accommodation and personal care for up to 70 older people. Some people also have dementia related needs.

The inspection was completed on 1 and 2 November 2016 and was unannounced. There were 57 people living at the service when we inspected.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and those acting on their behalf did not always think that there were sufficient numbers of staff available to meet their needs. The deployment of staff in communal lounge areas was not always appropriate and staff told us that they did not always have time to spend with the people they supported.

Minor improvements were needed to ensure that medicines management were conducted in line with the provider's policies and procedures. People told us the service was a safe place to live. Staff had a good understanding of safeguarding procedures to enable them to keep people safe.

Staff were able to demonstrate a good understanding and knowledge of people's specific support needs, so as to ensure theirs' and others' safety. Staff understood the risks and signs of potential abuse and the relevant safeguarding processes to follow. Risks to people's health and wellbeing were appropriately assessed, managed and reviewed. Staff were friendly, kind and caring towards the people they supported and care provided met people's individual care and support needs.

Staff received opportunities for training and this ensured that staff employed at the service had the right skills to meet people's needs. Staff felt supported and received appropriate formal supervision. Staff demonstrated a good understanding and awareness of how to treat people with respect and dignity.

The dining experience for people was positive and people were complimentary about the quality of meals provided. Consideration by staff was evident to ensure that eating and drinking was an important part of people's daily life and treated as a social occasion.

Where people lacked capacity to make day-to-day decisions about their care and support, we saw that decisions had been made in their best interests. The manager was up-to-date with recent changes to the law regarding the Deprivation of Liberty Safeguards (DoLS) and at the time of the inspection they were working with the local authority to make sure people's legal rights were being protected. People who used the service and their relatives were involved in making decisions about their care and support.

There was an effective system in place to regularly assess and monitor the quality of the service provided. The manager was able to demonstrate how they measured and analysed the care provided to people, and how this ensured that the service was operating safely and was continually improving to meet people's needs.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not consistently safe.

Arrangements were not always in place to ensure that the deployment of staff was suitable to support people safely.

Minor improvements were required to ensure that the management of medicines was appropriate.

Effective recruitment procedures were in place to safeguard people using the service.

Staff had a good understanding of safeguarding procedures to enable them to keep people safe.

Risks were managed and mitigated to ensure people's safety and wellbeing.

Is the service effective?

Good ●

The service was effective.

Staff were appropriately trained to meet people's needs. Staff felt supported and received regular supervision and an annual appraisal of their overall performance.

The dining experience for people was positive and people were supported to have adequate food and drinks.

People's healthcare needs were met and people were supported to have access to a variety of healthcare professionals and services.

Is the service caring?

Good ●

The service was caring.

People and their relatives were positive about the care and support provided at the service by staff. Our observations demonstrated that staff were friendly, kind and caring towards the people they supported.

People and their relatives told us they were involved in making decisions about their care and these were respected.

Staff demonstrated a good understanding and awareness of how to treat people with respect and dignity.

Is the service responsive?

Good ●

The service was responsive.

Improvements were required to ensure that people's care plans were sufficiently detailed and accurate.

People were supported to enjoy and participate in social activities of their choice or abilities.

Complaints management was robust and people using the service and those acting on their behalf felt confident to raise concerns.

Is the service well-led?

Good ●

The service was well-led.

The management team of the service were clear about their roles, responsibility and accountability and we found that staff were supported by the registered manager and other members of the management team.

Appropriate arrangements were in place to ensure that the service was well-run. Suitable quality assurance measures were in place to enable the provider and management team to monitor the service provided and to act where improvements were required.

Brookes House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 1 and 2 November 2016 and was unannounced. On the 1 and 2 November 2016 the inspection team consisted of two inspectors. On the 1 November 2016, the inspectors were accompanied by an expert by experience. An expert by experience is a person who has personal experience of caring for older people and people living with dementia. Additionally, the inspectors were accompanied on 1 November 2016 by an Inspection Manager. Their primary role was to undertake an observation of the inspectors practice and to be an active participant as part of the inspection process.

We reviewed the information we held about the service including safeguarding alerts and other notifications. This refers specifically to incidents, events and changes the provider and manager are required to notify us about by law.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 16 people who used the service, nine members of care staff, six relatives, the registered manager and two people responsible for providing activities to people living at the service. On the first day of inspection, the provider's representative [Area Manager for Brookes House] was also present.

We reviewed 10 people's care plans and care records. We looked at the service's staff support records for five members of staff. We also looked at the service's arrangements for the management of medicines, complaints and compliments information and quality monitoring and audit information.

Is the service safe?

Our findings

People's comments about staffing levels were variable. Some people felt on occasions that there were insufficient staff available to meet their needs. One person told us, "If I need to talk to staff they always listen to you, but of course they are so busy they cannot speak for long." Another person told us, "Although I am happy to sit in my room, no-one [staff] comes and has a chat with you. I know that they are busy but other than when my meals are brought to me, I am on my own." Two relatives told us, "There frequently appears not enough staff on duty and people do wait for their buzzer to be answered if they ring it" and, "You can often be visiting in the lounge and there is no staff in there. I have often alerted staff to a resident's needs." Staff's comments about staffing levels were variable. Some staff felt that staffing levels were appropriate whilst others advised that staffing levels were not always maintained as a result of staff sickness at short notice and the external agency utilised not being able to provide cover. Staff told us that when this happened, staff were unable to give or assist people with a bath or shower at a time or day of their choosing and they did not have enough time to simply sit and talk with them, other than when undertaking a care task.

Observations on the first day of inspection showed that the deployment of staff was not always suitable to meet people's needs. Both communal lounge areas on the ground floor were frequently left without staff support. For example, one communal lounge was left without staff support for a period of 45 minutes and when one person using the service required assistance with their personal care needs, another person who lived at the service had to press the call alarm so as to summon staff support. Additionally, throughout the first day of inspection, both people responsible for providing social activities to people living at the service were unable to achieve this properly as they were frequently undertaking care related tasks. We discussed the latter with the registered manager and were advised that this should not have happened and had not been brought to their attention.

Although suitable arrangements were in place to determine the basis for the service's staffing levels, so as to ensure that these remained suitable and flexible to meet people's individual care and support needs, the staff rosters for the period 10 October 2016 to 2 November 2016 inclusive showed that there were occasions when staffing levels as to told to us by the registered manager were not maintained. For example, the staff rosters for 28 October 2016, 29 October 2016, 30 October 2016, 31 October 2016 and 1 November 2016 showed that there were staffing shortfalls. Additionally, the staff rosters viewed were not accurate or reflective of staff on duty, and this was in part because there was no clarity to confirm the deputy manager's hours. For example, the registered manager confirmed that the deputy manager was contracted to work a total of 46 hours per week. This comprised of 24 supernumerary hours and 22 hours whereby they were included as part of the staffing numbers. However, the staff rosters provided no specific information to evidence this division of role. Therefore it was not possible to determine when they were included as part of the staffing numbers.

The registered manager confirmed a commitment to ensuring that these shortfalls and deployment issues would not occur in future.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored safely for the protection of people who used the service. We found that the arrangements for the management of medicines were generally satisfactory and safe. Arrangements were in place to record when medicines were received into the service and administered to people. We looked at the records for 10 of the 57 people who used the service. In general these were in good order, provided an account of medicines used and demonstrated that people were given their medicines as prescribed, with the exception of some emollient and topical creams. For example, the medication administration record for one person detailed that their topical cream used to prevent irritation to a person's skin should be applied to their body twice daily. The only entry recorded was for 28 October 2016 at 9.30 a.m. No other entries were recorded. This meant it was difficult to determine if staff had failed to apply the topical cream or solely failed to record the administration. This was not an isolated case and a further five people's records were incomplete. The registered manager confirmed that four days prior to our inspection a discussion with staff had been undertaken relating to the completion of people's topical cream charts and the application of this topical cream or medication. The registered manager confirmed that suitable arrangements would be put in place to monitor this for the future.

It was not clear if medication for one person was being used appropriately. The Medication Administration Record [MAR] showed they were prescribed a specific medication to deal with agitation and distress on an 'as and when required' basis. The MAR over a six day period demonstrated that this medication had been given by staff on eight occasions; however the person's behavioural records and daily care notes provided no rationale to demonstrate the circumstances surrounding the medication being administered by staff.

Observation of the medication rounds throughout the inspection showed these were completed with due regard to people's dignity and personal choice. Staff involved in the administration of medication had received appropriate training and competency assessments to ensure that they remained proficient to undertake this role to a safe standard. Regular audits had been completed and these highlighted no areas for corrective action.

Staff's practice reflected that risks to people were managed well so as to ensure their wellbeing and to help keep people safe. Environmental risks, for example, those relating to the service's fire arrangements were in place and this included individual Personal Emergency Evacuation Plans (PEEP). These ensured that the provider was able to respond effectively to untoward incidents and other emergencies that may occur at the service.

Staff told us that efforts were made to keep people safe at all times. People confirmed to us that staff looked after them well, that their safety was maintained and they had no concerns. People also told us that they felt safe and secure. One person told us, "I do feel very safe here because I am not very sociable and like to stay in my room; but there is a book over there and someone [staff] comes in every hour to check I am okay and they sign the book." Another person told us, "The staff here will always make you feel safe. If you are worried staff will talk to you but they are very busy." One relative confirmed that as a result of their member of family experiencing several falls, appropriate arrangements had been put in place by the organisation for an alarm mat to be introduced. This is to alert staff if the person using the service should get up from their bed or chair and enable them enough time to attend to their needs. The relative told us that as a result of this, "I have no worries about their safety now."

Staff had received appropriate safeguarding training. Staff were able to demonstrate a good understanding and awareness of the different types of abuse, how to respond appropriately where abuse was suspected

and how to escalate any concerns about a person's safety to a senior member of staff or a member of the management team. Staff also confirmed they would report any concerns to external agencies such as the Local Authority or the Care Quality Commission if they felt that the management team or registered provider were not responsive. Staff were confident that the registered manager and deputy manager would act appropriately on people's behalf. Where appropriate suitable measures had been carried out by the registered manager to take action and alert all relevant parties where abuse had been alleged or suspected. Records were well maintained including details of the alleged or suspected abuse, investigation report and accompanying documentation and the outcome if known.

Suitable arrangements were in place to ensure that the right staff were employed at the service. Staff recruitment records for five members of staff appointed within the last 12 months showed that the provider had operated a thorough recruitment procedure in line with their policy and procedure. The recruitment procedure included processing prospective staff member's employment application, conducting interviews, seeking references and undertaking a Disclosure and Barring Service [DBS] check. This showed that staff employed had had the appropriate checks to ensure that they were suitable to work with the people they supported.

Is the service effective?

Our findings

Staff confirmed that they received regular training opportunities, both face-to-face and online in a range of subjects and this provided them with the skills and knowledge to undertake their role and responsibilities and to meet people's needs to an appropriate standard. Staff told us that this ensured that their knowledge was current and up-to-date. Records confirmed what staff had told us and showed that their mandatory training as agreed by the provider was up-to-date. The registered manager confirmed that in order to enhance the provider's existing dementia training and improve staffs knowledge, additional workshops had been undertaken and completed. Further training relating to people who could become anxious and distressed was required to be considered for the future. We discussed this with the registered manager and they provided an assurance that this topic would be considered for the future, particularly as several people using the service could become anxious and distressed.

The registered manager confirmed that all newly employed staff received a comprehensive induction. This related to both an 'in-house' orientation induction and completion of the Skills for Care 'Care Certificate' or an equivalent. Staff told us that in addition to the above they were given the opportunity to 'shadow' and work alongside more experienced members of staff. The registered manager confirmed that this could be flexible according to previous experience and level of competence.

Staff confirmed that they received regular supervision and were supported by the registered manager and other members of the senior management team. Staff told us that they felt valued by the registered manager, that they were approachable and proactive in dealing with issues raised. In addition, staff told us and records confirmed that staff employed longer than 12 months had received an appraisal of their overall performance for the preceding 12 months.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Not all staff were able to demonstrate a good knowledge and understanding of MCA and Deprivation of Liberty Safeguards (DoLS) despite having received training. The registered manager confirmed that they would look at sourcing additional training in this area for staff as soon as possible. Records showed that where appropriate people who used the service had had their capacity to make decisions assessed. This

meant that people's ability to make some decisions, or the decisions that they may need help with and the reason as to why it was in the person's best interests had been recorded in most cases. However, assessments had not been considered or completed where people had an alarm mat in place to alert staff when they got out of bed to mobilise. This showed that a management plan had not been completed to confirm that this decision was in the person's best interest and the least restrictive option available. Where people were deprived of their liberty, the provider had made appropriate applications to the Local Authority for DoLS assessments to be considered for approval. Where these had been authorised the provider had notified the Care Quality Commission.

People were observed being offered choices throughout the day and these included decisions about their day-to-day care needs. People told us that they could choose what time they got up in the morning and the time they retired to bed each day, what items of clothing they wished to wear, where they ate their meals and whether or not they participated in social activities.

People were positive about the meals provided. One person told us, "The staff know your likes and dislikes. I do not like food very much so they [staff] give me an omelette and I do not have to ask now as the staff know I will only eat this." A second person told us, "There is always plenty of food here and you can ask for more." Observation of the dining experience for people over both days of the inspection was noted to be relaxed, friendly and unhurried; with staff conversing with people using the service. People were supported to make daily choices from the menu provided and received food in sufficient quantities. Where people required assistance and support to eat and drink this was provided in a sensitive and dignified manner, for example, people were not rushed to eat their meal and were able to enjoy the dining experience at their own pace. People were routinely offered a 'second helping' and people were asked if they had finished their meal before the plate or bowl was removed.

People told us that their healthcare needs were well managed. One person told us that they had been unwell and as a result of this staff had called their GP. They followed this by stating, "If you are unwell they [staff] will always call someone for you." Relatives confirmed that they were kept informed of their member of family's healthcare needs and the outcome of healthcare appointments. One relative told us, "Generally if your member of family has a health issue they [staff] will chase it up, but I don't let things rest." People's care records showed that their healthcare needs were clearly recorded and this included evidence of staff interventions and the outcomes of healthcare appointments. Each person was noted to have access to local healthcare services and healthcare professionals so as to maintain their health and wellbeing, for example, to attend hospital appointments and to see their GP. Healthcare professionals were complimentary about the care and support provided by staff employed at the service. They told us that advice and guidance provided by them or other members of their team to staff at the service was always followed. In addition staff were responsive and proactive to people's care and support needs and referrals were provided at the earliest opportunity. The healthcare professionals advised that there was a good working relationship between the management team, staff at the service and the local healthcare professional team.

Is the service caring?

Our findings

People were satisfied and happy with the care and support they received. One person told us, "They [staff] will always ask you what you want them to carry out. They are very good." Another person told us, "The staff are very caring when they have to help you of a morning." All relatives spoken with confirmed that they were happy with the care and support provided for their member of family. One relative told us, "The staff are very caring to my relative." Another relative told us, "My relative is very well cared for here and I have never had to complain."

We observed that staff interactions with people were positive and the atmosphere within the service was seen to be calm and friendly. Staff were noted to have a good rapport with the people they supported and there was much good humoured banter during both days of the inspection which people appeared to enjoy.

Staff understood people's care needs and the things that were important to them in their lives, for example, members of their family, key events, hobbies and personal interests. People were also encouraged to make day-to-day choices and their independence was promoted and encouraged where appropriate and according to their abilities. One person told us, "Staff respect my independence and let me do things for myself." Our observations showed that several people at lunchtime were supported to maintain their independence to eat their meal and some people confirmed that they were able to manage some aspects of their personal care with limited staff support. In addition, one person told us that they regularly accessed the local town centre independently so that they could complete personal shopping. People confirmed that where appropriate they had a key to their room and could come and go as they pleased.

Staff were able to verbally give good examples of what dignity meant to them, for example, knocking on doors, keeping the door and curtains closed during personal care and providing explanations to people about the care and support to be provided. Our observations showed that staff respected people's privacy and dignity. We saw that staff knocked on people's doors before entering and staff were observed to use the term of address favoured by the individual. In addition, we saw that people were supported to maintain their personal appearance so as to ensure their self-esteem and sense of self-worth. People were supported to wear clothes that they liked, that suited their individual needs, were colour co-ordinated, included jewellery and were appropriate to the occasion and time of year. In addition, one member of staff was observed to assist a person to walk from the dining room to a communal lounge. The member of staff supported them by walking beside them and placing their hand on the person's back so as to provide comfort and reassurance. The member of staff walked at the person's pace, showing patience, kindness and understanding in their approach. As we waited for the person and the member of staff to pass us in the corridor the member of staff sensitively made us aware by non-verbal cues that the person had a sensory impairment and required time to mobilise. This demonstrated that the member of staff was knowledgeable about the person's individual needs and treated them with respect and dignity.

People were supported to maintain relationships with others. People's relatives and those acting on their behalf visited at any time. Staff told us that people's friends and family were welcome at all times. Relatives

confirmed that there were no restrictions when they visited and that they were always made to feel welcome. Visitors told us that they always felt welcomed when they visited the service and could stay as long as they wanted.

Is the service responsive?

Our findings

Appropriate arrangements were in place to assess the needs of people prior to admission. This ensured that the service were able to meet the person's needs. Evidence showed that, where able, people and those acting on their behalf had been involved in the development and review of their care plan. Relatives told us that they had had the opportunity to contribute and be involved in their member of family's care and support. As part of the pre-admission assessment process and where life histories were recorded there was evidence to show that where appropriate these had been completed with the person's relative or those acting on their behalf.

Although some people's care plans provided sufficient detail to give staff the information they needed to provide personalised care and support that was consistent and responsive to their individual needs, others were not as fully reflective or accurate of people's care needs as they should be. For example, outcomes of referrals following interventions provided by healthcare professionals and information recorded within the staff handover book were not always up-dated and included within the person's care plan. Additionally, some information viewed was noted to be contradictory. Whilst care plans were regularly reviewed and where a person's needs had changed, these had not always been updated to reflect the new information. Although the above was found and this meant that there was a potential risk that relevant information was not captured for use by care staff or provided sufficient evidence to show that appropriate care was being provided and delivered, we found no impact to suggest that care provided was not responsive. However, the shortfalls showed that improvements were required in relation to records management.

Staff told us that they were made aware of changes in people's needs through handover meetings prior to each shift and discussions with senior members of staff and the management team. This meant that staff had the information required so as to ensure that people who used the service would receive the care and support they needed.

People told us that those responsible for providing social activities at the service were good and that they were generally happy with the activities provided. A programme of social activities was planned each week and this was displayed for peoples' information. We were told that the choice of activities was flexible and this could be changed to accommodate people's choice and preferences. People confirmed that they had a choice as to whether or not they participated in social activities. One person told us, "I don't do much but I am happy with that." Another person told us, "If I want to join in with the activities I can. Sometimes I do, sometimes I don't." As previously stated both people responsible for providing social activities to people living at the service were unable to achieve this properly as they were frequently undertaking care related tasks. We discussed the latter with the registered manager and were advised that this should not have happened and had not been brought to their attention.

People spoken with knew how to make a complaint and who to complain to. People and their relatives told us that if they had any concern they would discuss these with the management team or staff on duty. The service had an effective complaints procedure in place for people to use if they had a concern or were not happy with the service. The complaints log was well maintained and showed that within the last 12 months

there had been four complaints. A record was kept of all issues raised, action taken and the outcome. A record of compliments was also maintained so as to capture the service's achievements.

Is the service well-led?

Our findings

The registered manager was able to demonstrate to us the arrangements in place to regularly assess and monitor the quality of the service provided. This included the use of questionnaires for people who used the service and those acting on their behalf. In addition to this the registered manager monitored the quality of the service through the completion of a number of audits. This also included an internal review of the service by the provider, which had been revised in line with our new approach to inspecting adult social care services introduced in October 2014.

A review of audits completed since the appointment of the registered manager in February 2016, showed that significant improvements had been made by them to improve the quality and safety of service provision. For example, prior to the current manager's appointment the audit relating to safeguarding scored 54%. Since this time the registered manager had achieved a score of 79%. The registered manager was able to show that learning from past practices and incidents had been made. Although this inspection had highlighted areas for further development, the registered manager was fully aware of the improvements to be made and the actions to be taken to address these, such as, improvements relating to records management for people using the service. Minutes of recent staff meetings showed that where improvements were required, these had been discussed with the senior management team and care staff; and systems were in place to action these. Following our inspection the registered manager sent us an action plan detailing what would be done to make the necessary improvements and to achieve compliance. This provided an assurance that the registered manager was proactive and keen to improve the quality of the service provided for people living at Brookes House.

Relatives and staff had positive comments about the management of the service. Staff were clear about the registered manager's and provider's expectations of them and staff told us they were well supported. Comments from relatives included, "The manager here is very friendly and approachable and they will always speak with you" and, "You can phone up if you have any issues and the manager is very helpful." Staff confirmed that although the registered manager had only been in post since February 2016, they were very positive about the influence and impact they had on the overall day-to-day management of the service. Staff felt that the service was well run and although there had been many changes, in staff's opinion these had been positive. Staff told us that their views were respected and they felt able to express their opinions freely. Staff felt that the overall culture across the service was open and inclusive and that communication was generally good. This meant that the provider and management team of the service promoted a positive culture that was person centred, open and inclusive.

People living at the service, their relatives and those acting on their behalf and staff had completed satisfaction surveys in March 2016. The summary report recorded that no responses had been received from people using the service, only five relatives and one member of staff had provided a response. These showed that overall relatives were satisfied with the general quality of the service provided. Where areas for improvement were highlighted for corrective action, an action plan had been completed and this included the actions taken to make the necessary improvements.

The registered manager confirmed that the service was part of the Promoting Safer Provision of Care for Elderly Residents (PROSPER) project in relation to falls, urinary tract infections and pressure ulcers management. This is a project that aims to improve safety, reduce harm and reduce emergency hospital admissions for people living in care homes across Essex by developing the skills of staff employed within the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing We found that the registered provider had not ensured that there were sufficient numbers of staff deployed so as to make sure that they can meet people's care and treatment needs.